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# ‘There’s no Hope for any kind of decent life’

## A qualitative study to explore the perspectives of people experiencing homelessness with a recent non-fatal overdose in Scotland

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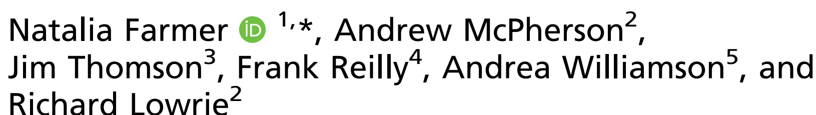
# 'There's No Hope for Any Kind of Decent Life': A Qualitative Study to Explore the Perspectives of People Experiencing Homelessness with a Recent Non-Fatal Overdose in Scotland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## Abstract

The past ten years has seen a marked increase in the numbers of people experiencing homelessness globally and an associated public health epidemic of drug-related deaths. Drawing from qualitative interviews as part of a wider pilot randomised controlled trial (RCT) conducted in Glasgow, Scotland with National Health Service pharmacists and third sector homeless outreach caseworkers, insights from those with living experience of both homelessness and a recent non-fatal drug overdose will be presented. Twenty people experiencing homelessness with at least one drug overdose in the past six months were interviewed in person, in a homelessness drop in centre or in emergency accommodation between November 2021 and

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January 2022. Findings from our study indicate that participants' drug use and overdose risk were exacerbated during the Covid-19 pandemic due to the pervasive availability of illicit drugs for those placed in emergency accommodation, alongside reduced support and access to health and social care services. Additionally, multi-agency stressors such as a lack of autonomy and dehumanising experiences were reported, leading to a significant sense of powerlessness. Furthermore, the necessity of advocacy-based services as critical aspects of support was identified, with importance placed upon dedicated, homelessness staff and access to safe environments.

**Keywords:** homelessness, inequality, substance use, trauma

*Accepted: June 2023*

## Introduction

The past decade has seen a rapid rise in numbers of people experiencing homelessness (United Nations, 2020) and is predicted to increase as we enter a more profound 'cost of living' period (Watts *et al.*, 2022). Furthermore, homelessness and drug overdose mortality are interconnected and have a bi-directional causal pathway (Doran *et al.*, 2022) and in Scotland more than half of all homeless deaths are drug related (National Records of Scotland, 2022a). Despite the Scottish Government providing additional investment in recent years, targeted at the formation of a Drug Deaths Taskforce, with a further £20 million invested over five years (Audit Scotland, 2022), it is against a backdrop of a decade long UK Government austerity agenda. This has impacted upon integrated social work services and health addiction teams, known as Alcohol and Drug Recovery Services (ADRS), leading to increased risk for drug-related deaths amongst the most socio-economically deprived communities (McPhee and Sheridan, 2020). ADRS teams are comprised of multidisciplinary health and social care workers who collaborate with homelessness services, third sector organisations and acute health services in order to address complex needs associated with problematic drug and alcohol use. In 2020, as a response to the Covid-19 pandemic, the UK Government announced the *Everyone In* initiative that aimed to reduce rough sleeping and is said to have saved at least 226 lives (Kerslake, 2021). This contrasts starkly with recent statistics detailing drug-related deaths in people experiencing homelessness during Covid-19, most of which occurred in emergency accommodation (Keast *et al.*, 2022).

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## Homelessness and overdose

Homelessness and substance misuse form two of the core triad of severe and multiple disadvantage in Scotland (Hard Edges Scotland, 2019) and there is unequivocal evidence that people experiencing homelessness who also use drugs experience severe health inequalities (Aldridge *et al.*, 2018), contributing to unmet health and social needs, creating adverse health outcomes (Nyamathi and Salem, 2021). In an attempt to address health disparities, in-reach models of care by integrated health and social care teams have been established (Armstrong *et al.*, 2021). This is an important model because people who experience homelessness and use drugs often encounter barriers when accessing traditional health and social care services because of institutionalised stigma and the need to prioritise food and shelter over healthcare (Doran *et al.*, 2022). Specifically, peer-delivered interventions have been found to be effective due to support workers' ability to develop meaningful and trusting relationships and improve engagement (Parkes *et al.*, 2022). Severe and multiple disadvantage is often a result of trauma in childhood and adolescence (Hard Edges Scotland, 2019). However, trauma-informed interventions can be difficult to access in people experiencing homelessness due to a lack of therapeutic space and the frequency of substance use in this cohort (Bennett *et al.*, 2022). In an attempt to address this as part of a wider approach for people who use drugs to promote recovery, the devolved administration in Scotland has recently published the Medication-Assisted Treatment (MAT) standards. The national standards are designed to reduce drug-related harms and ensure consistent access to safe and high-quality treatment by encouraging and supporting people to make informed choices underpinned by trauma-informed care (Scottish Government, 2021).

## Drug overdose prevention

The Scottish national naloxone programme was established in 2010, in order to prevent fatal opioid overdoes in Scotland (McAuley *et al.*, 2012). However, Scotland continues to record the highest number of drug-related deaths in Europe, which has more than doubled since the naloxone programme began (National Records of Scotland, 2022b). There are now calls for a radical response to address drug-related mortality, such as the decriminalisation for possession of illicit drugs (Christie, 2021). The politicisation of illicit drug use and overdose is thought to contribute towards drug-related harms (Matheson and Robertson, 2022). For example, overdose prevention sites (drug consumption rooms) are seen as a feasible method to prevent harm and provide supportive environments to intervene in overdose, yet the UK

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government has rejected calls for their establishment, citing the Misuse of Drugs Act 1971 as defence to negate the scheme (Shorter *et al.*, 2022). This is despite evidence suggesting that injection drug users would be willing to utilise them (Trayner *et al.*, 2021), with results from the UK's first unsanctioned overdose prevention site indicating that it is an ideal location to provide overdose intervention (Shorter *et al.*, 2022). Drug testing uses technologies to examine the contents of illicit drugs prior to their use. Fentanyl test strips is an example of this and used as part of a wider harm reduction strategy, is another method shown to impact positively on opioid-related overdose (Peiper *et al.*, 2019).

Whilst methadone is widely recognised to reduce heroin use and related mortality (Mattick *et al.*, 2009), methadone and naloxone should not be seen as panaceas to overdose prevention. For instance, latest toxicology figures from Scotland reveal methadone as the most common substance found in individuals who died from drug-related causes (National Records of Scotland, 2022b). Although naloxone is seen as instrumental in combatting overdose from opioids, there has been a change in drug use in Scotland. For example, benzodiazepines, particularly new psychoactive substances such as etizolam are acknowledged as an important antecedent in recent drug-related mortality (McAuley *et al.*, 2022) and 93 per cent of all drug-related deaths featured more than one substance as a causal factor (National Records of Scotland, 2022c), bringing into question the need for interventions that are primarily based on methadone and naloxone.

## Study aims

Despite a clear association between homelessness and drug-related mortality (Fine *et al.*, 2022), further research is required to develop specific interventions to address this, informed by the perspectives of people with lived experience of health and social care in this context. Integrated health and social care services form the legislative requirements of the 2014 Public Bodies (Joint Working) (Scotland) Act to ensure quality access to service provision alongside the Scottish Government's commitment towards ensuring those with lived experience inform policy development (Changing Lives, 2022). However, we found little evidence within the literature from the perspectives of people who are both homeless and have experienced a recent non-fatal overdose. The lack of lived experience is an important omission and addressing this is crucial for policy and practice. This would help inform future service delivery and ensure health and social care teams fully comprehend the challenges in meeting the needs of people experiencing homelessness with a recent non-fatal overdose. This study aims to address the lack of service user voice from the perspective of people experiencing homelessness with a

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recent non-fatal overdose with a view of gaining an insight into what aspects of support are perceived as most significant in order to prevent drug overdose.

## Methods

The Pharmacist and Third Sector Homeless Outreach Engagement Non-medical Independent prescribing Rx (PHOENIx) is a collaboration between National Health Service independent prescriber pharmacists, and third sector homelessness support workers with lived experience of homelessness from Simon Community Scotland or Marie Trust in Glasgow, Scotland. PHOENIx assertively outreach every week to assess and offer support with housing, welfare benefits and wide-ranging health issues (Lowrie *et al.*, 2021). This qualitative study was part of a wider pilot randomised controlled trial (RCT) of the PHOENIx intervention (Lowrie *et al.*, 2022) and was conducted to provide insights from participants that might not ordinarily be available from traditional RCT data to further contextualise findings (O'Cathain *et al.*, 2013). Advice was gathered from people with lived experience of homelessness and non-fatal overdose and Simon Community support workers when designing the interview questions and during the data analysis phase, including use of appropriate terminology and rigour in the interpretation of emerging themes. Ethical approval was obtained from the South East Scotland National Health Service Research Ethics Committee and governance approval by NHS Greater Glasgow and Clyde Research and Innovation.

## Participants

Participants ($n = 20$) for the qualitative interviews were recruited from the intervention group ($n = 62$) of the PHOENIx after overdose pilot RCT. Eligibility criteria were adults (eighteen years old or over) who were homeless and had experienced at least one non-fatal drug overdose in the past six months. Independent researchers A.M. and N.F. purposively sampled participants with particular knowledge of the context of homelessness and non-fatal overdose. To capture the widest range of perspectives possible, heterogeneous sampling techniques were utilised to ensure variation across gender, age, accommodation and number of overdoses. A.M. established an initial face-to-face relationship with the study participants when informed consent was obtained to participate in the RCT. A.M. then carried out a baseline assessment with participants and was then able to identify individuals who expressed an interest in the qualitative component of the RCT and were willing to share their

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**Table 1.** Sample characteristics

| | |
|---|---|
| Sex | |
| Male | 13 (65 per cent) |
| Female | 7 (35 per cent) |
| Age | |
| Mean (SD) | 45 (8.7) |
| Number of overdoses (past six months) | |
| Median (range) | 2 (1–30) |
| Accommodation | |
| Supported | 6 (30 per cent) |
| Unsupported | 12 (60 per cent) |
| Hospital | 2 (10 per cent) |
| Opiate substitute therapy | |
| Methadone | 18 (90 per cent) |
| Buprenorphine | 1 (5 per cent) |
| Nil | 1 (5 per cent) |
| Methadone dose (mg/ml) | |
| Mean (SD) | 90(22.8) |
| Received diazepam prescription | |
| Yes | 1 (5 per cent) |
| No | 19 (95 per cent) |
| Naloxone | |
| Possess Naloxone | 12 (60 per cent) |
| Knows how to use it | 17 (85 per cent) |
| Alcohol and drug recovery service | |
| Generic ADRS | 13 (65 per cent) |
| Homeless ADRS | 6 (30 per cent) |
| Not known to ADRS | 1 (5 per cent) |

SD, standard deviation.

experiences. Basic socio-demographic characteristics of participants are provided in Table 1.

## Data collection and analysis

Interviews were conducted by N.F., a qualified social worker and academic researcher in social work and not involved in the delivery of the trial intervention. Data were gathered from twenty participants in face-to-face semi-structured interviews between November 2021 and January 2022 either at a city centre third sector space where people attend for a wide range of social and health care input (Simon Community Scotland Hub) or in their supported or unsupported accommodation. Interviews lasted an average of 40 min, ranging from 30 to 60 min and recorded on an audio-digital recording device with participants' consent and then transcribed verbatim by an independent company verified by the NHS, using pseudonyms to ensure confidentiality and anonymity. All study participants received a £10 shopping voucher in recognition for their participation. Transcripts were then entered into NVivo Version12 software

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and analysed by the study team using reflexive thematic analysis (RTA) (Braun and Clarke, 2021). This approach was chosen in contrast to other thematic methods because it has been successfully utilised within health and social care research to explore patients' perspectives and lived experience (Shannon *et al.*, 2022). It also provides a systematic framework that enables researchers to consider their own positionality within the research process and knowledge production. Reflexivity within research is often fraught with ambiguity due to researcher positionality, such as role, identity and power that can influence the research process (Corlett and Mavin, 2018). Therefore, consideration in relation to our positionality as researchers was crucial and approached collectively by integrating the reflexive pair interview method (Gilmore and Kenny, 2015). This involved N.F. and A.M. working together in the data analysis stage, acknowledging the limitations that may occur as lone researchers. As outlined by Clarke and Braun (2013), the team followed the four stages of analysis: orientation with the data (N.F. and A.M.), generation of initial codes (N.F. and A.M.), developing themes (N.F.), reviewing themes (N.F. and A.M.), defining and naming themes (N.F., A.M., R.L. and J.T.) and writing the analysis (N.F.).

## Results

Three major themes and associated subthemes were generated from our analyses from the qualitative interviews of those with living experience of both homelessness non-fatal overdose including: (1) impact of the Covid-19 pandemic on mental health, housing insecurity and access to service provision, (2) increased sense of powerlessness from multi-agency stressors and (3) advocacy-based services as critical aspects of support.

## Covid-19 pandemic

### Increased levels of fear and anxiety

Participants described current perspectives of drug use and overdose and this revealed a significant sense of loss and hopelessness linked to both histories of past trauma, alongside an increased sense of fear and anxiety that escalated during the pandemic. Whilst many highlighted that early experiences of abuse, neglect and structural inequality were significant reasons that initially led them to use drugs, the impact of the pandemic was a significant re-traumatising risk factor for overdose. Several participants discussed the death of loved ones to Covid-19 and the impact this had on their mental health, alongside challenges accessing specific services:

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> I loved Diane, I really did. It's still hard, there's still a gap in my life, but I feel as if it's coming from my stomach and I try to stop it, try to stop thinking about her, because any time I start talking about her I start crying [...] They keep saying about bereavement counselling but nothing's ever came of it. (Barry)

> See once I lost them two, I just fell to pieces completely and from then on, I was in, out, in, out of [Scottish Prison Service]. Seven days, I lost the two people that I love. It's not been nice at all. My doctor didn't even give me any depression tablets or anything. Wouldn't give me anything. (Matthew)

Participants explained how the pandemic had amplified the complex challenges already present in their lives linked to housing insecurity, financial uncertainties and chronic health conditions, which were emphasised as particular risk factors for drug use and overdose. For some, an increased sense of isolation had created feelings of paranoia associated with previous trauma and exposure to violence. Overall, fear emerged as a consequence of the pandemic that exacerbated drug overdose, with many expressing the need to self-medicate in order to cope with current realities:

> What made me keep doing it? Fear. In the fear in thinking there's no hope for any kind of decent life [...] So, I think that's why I continued, just try to block it all out. Wasn't caring about the consequences. I overdosed something like 28 times. Pronounced dead something like 18 times. And did it stop me doing it? Nothing stopped me doing it. (Lee)

## Trapped in a toxic environment

Participants reported negative experiences within unsupported emergency accommodation, often referred to interchangeably as 'hotels', 'hostels' or 'B&Bs.' Despite the success of the *Everyone In* scheme that provided emergency accommodation to those rough sleeping during the pandemic, many identified this as a risk factor for overdose. Feeling isolated and trapped were frequently reported emotions:

> I found the hotels particularly brutal because you can't get away from it, you get guys standing at the bottom trying to sell you. Just in the city centre, because people knew you, it was just, boom, right in your face, constant. During that Covid period, you couldn't go anywhere, you were bottom of the hotel, you were basically caught whether you wanted to or no. (Chris)

Emergency accommodation was described as a 'nightmare' due to peer pressure, abuse and the increased prevalence and availability of drugs and alcohol that many stated was out of control. Specifically, the accessibility of illicit street Valium was emphasised:

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> The hostels were the cause of the drugs. Hostels are running with drugs [...] I'll buy them just to pass time. And that's because I was in and out of hostels, sitting in that room, single bed, no telly, no nothing and I know myself, just taking Valium like sweeties. I was buying 1000 at a time. (Daniel)

Alongside these identified risks, the re-traumatising impact of emergency accommodation in regards to mental and physical health was discussed. This was in relation to inadequate living conditions, especially after discharge from hospital, such as lack of access to essential facilities (kitchen, washing machines, fridges or TVs), alongside the impact of regularly witnessing death.

> Eight people have died just in that [B & B] alone. Three of my neighbours. One there, one there, and your man across by taking his dodgy street Valium. That affects me, and then I lost my pal and all. Died with street Valium. (Paul)

> I nearly died this time last year, I was in a coma, induced coma for a week and I was six stone when I came out of it, six stone. Still not fully fit but I'm getting there and that's another reason I need to get out of there, no hot meals you know, it's rubbish food in the hostels. (Sean)

## Abandonment: Services 'missing in action'

Interviews were conducted when health and social care settings were still operating under emergency policies and procedures due to Covid-19 and participants expressed challenges accessing statutory ADRS, creating a sense of abandonment. These involved difficulties securing face-to-face appointments, a reliance on virtual meetings, with little outreach or follow ups provided when requested:

> The addiction services, they're absolutely hit and miss [...] My key worker went sick and they didn't allocate anybody else to me and then a year passed, and she just sacked it. It took me trying to trying to jump in the water along at the [river] Clyde for them to actually put somebody else in place. (Chris)

Engagement with ADRS was often described as 'difficult' for a variety of reasons that were linked to a lack of communication and inconsistency. For example, describing her experience with ADRS, Caroline expressed concerns that impacted upon her ability to engage with staff:

> I thought they were a disgrace [...] No support, no help, nothing that you want to open up to them and say to them 'going to please help me it's something that I injected myself with I've done it wrong, going to help me I'm scared I'm going to die tonight' [...] I just close down. I don't go back to social workers, the ADRS team workers, I thought they were meant to be wanting to help us. (Caroline)

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Alternatively, for others, although the pandemic exacerbated the ability to secure statutory support, engagement with third sector providers who were providing face-to-face appointments had increased:

> I didn't get any addiction appointments; that is why I was along at the [Third Sector Organisation]. It's almost as if they don't want you to go to the [ADRS Team] because of Covid. The addiction services were missing in action as far as I'm concerned at that time. (Chris)

## Multi-agency stressors

### Lack of autonomy

Although participants reported that the impact of the pandemic had negatively affected their interactions with health and social care professionals, certain aspects pre-dated the pandemic, and were ongoing sources of stress that many felt escalated their drug use and risk of overdose. For instance, there was a significant sense of powerlessness in terms of choice and access to various services. This was related to recovery-based programmes, such as residential treatment (rehab and detox units), with aspects such as 'funding', 'waiting times' and being 'too unstable' often described as justifications that access had been denied:

> But I feel as if I've been let down by a lot of agencies, people [...] I've been let down by doctors and all, I've tried to get into rehab. (Sean)

> My case worker tried to get me an abstinence-based project [...] My pal was in and it really helped. A different person in my eyes and she's clean and she's got a wee dog and a life again, she's got a normal life. They won't get me intensive [treatment] because they think I'm too unstable. (Sophie)

Furthermore, participants who were successful accessing crisis centres for short-term support highlighted additional tensions when attempting to access longer term recovery options:

> They sort of stabilise you and try and get you somewhere else to go after there [...] They have to take you in for a few weeks and then basically move to a hostel. They can't get you into rehabilitation places. I don't know whether it's funding or places? It just seems their hands are always tied and I mean you can see the frustration in workers faces. They really know what you want and you need it, you know? (Lee)

Another significant issue reported was unhappiness with methadone prescriptions, and participants described a lack of input into decision-making, stating that they did not feel listened to. For Brian, he expressed frustration with long-term methadone prescriptions, and was regularly using cocaine and street Valium.

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> I don't think health professionals have helped me manage to it. The [ADRS] team, no. The methadone is a fucking terrible thing. Anytime you're going in saying that you've used once or twice and you're opening up about it like, 'Well we'll put you up another 10 ml.' And that was their answer to everything. It should be a drug that's used for fucking assisting you to get off heroin for maybe six weeks. (Brian)

Despite communicating frustrations with health and social care workers, many spoke about the desperation that the lack of choice in relation to long-term methadone prescriptions had created for them, with a sense of desperation evident:

> I've been saying to them for months, I don't want to go on methadone. I need to get it out of my life [...] it's now the New Year and nobody has contacted me [...] It's my body and I don't want to be on it, I should have a say in this, it's me that has to take it every day.
>
> What is it about being on it that you don't like?
>
> I hate going to the chemist every day [...] the anxiety that builds up in me, if I go to the chemist the next day, they don't believe how bad it is, I need to build up the courage to actually go to the chemist and they've got me going six days, that's fucking ridiculous, but it's as if they're not listening and I'm like, 'What, does it take for me to hang myself again for you to listen? (Clare)

## Dehumanisation

The majority of participants reported 'humiliating' experiences that left them feeling powerless in various multi-agency settings. This was often associated with discriminatory treatment from staff working in essential services that resulted in a high level of mistrust. Participants highlighted that previous stigmatising attitudes towards them were normalised behaviours that had a detrimental effect on their engagement:

> I refuse to go [to the acute hospital]. Only because of the way the nurses treat you. They're fine until you say to them, in my records, because it says about the methadone and that. And it's straightaway, you can just see them. Their eyes on us, you see it in their faces. (Euan)
>
> Second class citizen, even in the chemist. It's like, put yourself first and I'm told to get outside because I'm a second-class citizen [...] how about a little bit of professionalism and support. (Pauline)

For women, interactions within the child protection system were often characterised as a factor that increased feelings of stigmatisation and powerlessness. Most of the women interviewed had previous or ongoing involvement with children and families social work due to concerns of

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parental substance misuse and difficulties during Child Protection Case Conferences (CPCC) were reported:

> There was everybody all doing a big meeting to see if I can take my kid out the hospital, and there's a guy that's chairing the meeting, you've got nurses who haven't met you before [...] you've got your [ADRS] team workers, you've got your police, you've got all these social workers they are all there to give their opinion. I felt like a paedophile [...] I was so angry. I was honestly feeling like an animal. They were poking me like a bear. (Caroline)

In some cases, abuses of authority were reported that left participants feeling dehumanised and humiliated. Two participants described distressing incidents of being strip searched in different contexts, with one leading to a legal case in court, creating ongoing levels of anxiety in relation to future interactions with professionals:

> I've had bad things happening to me with the police. Every time they jail me they want to strip search me [...] It destroys me. I was naked to boxers in the cell and it was winter and it was pure freezing. It fucked me out of my head, and they're doing it to me all the time. (Paul)

In another example, Clare recalled the impact of being strip searched in a Detox Unit and subsequently struggling with anxiety and panic attacks:

> They wanted to strip search me and so obviously they're not allowed to strip search you, so I'm suing them, they've admitted liability. It was total humiliation. She never gave me a towel or a sheet or anything, she made me stand there with no clothes on for about 15 minutes while she went through all my stuff, which was total humiliation. (Clare)

## 'With the right support, anything is possible': Creating and sustaining hope

### Persistent advocacy

Persistent advocacy was highlighted by all participants as a vital factor in terms of not only preventing overdose, but in creating and sustaining hope that many felt was significantly absent in their life. This involved the importance of dedicated caseworkers committed to challenging the widespread barriers people experience when attempting to access health and social care services at the intersection of homelessness and drug use. Third sector advocacy was highly valued by participants as an essential aspect of support that helped to counteract the barriers securing statutory service provision.

> They are persistent [...] They are very positive and that gives me hope [...] The fact that they are there for me is like a boost, it's like I've got

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> somebody in my corner you know, when you've actually got no one there right. I have now got somebody [...] to have them backing you up, you can't buy that you know what I mean. (Brian)

There was a sense that the 'right support' at the 'right time' was crucial in terms of preventing overdose related to the extreme unhappiness many participants expressed in terms of feeling abandoned and 'unheard'. For Anna, the persistent advocacy the PHOENIx team provided for her was crucial in terms of delivering the physical health support she required for Hepatitis C and sepsis, combined with securing her a place in a residential support service:

> I wouldn't be here if it wasn't for [PHOENIx Team], they went above and beyond for me they really did. I'd probably be dead to be honest with you [...] when I needed somewhere to stay when I was getting passed about from hostel to hostel, they would phone for me and get me taxis to the chemist when my leg was sore and stuff. If it wasn't for them I wouldn't have gone into the Crisis Centre. I wouldn't have went into [residential and day support] and got myself clean [...] Before I had nobody's support so I just kept going back into using drugs. (Anna)

For others, alongside support with physical health co-morbidities (i.e. seizures, abscesses, diabetes, hepatitis and stroke) challenges due to memory loss emerged repeatedly, and valued support included advocacy with necessary social security forms and appointments. This included outreach visits to complete social security applications; access electricity vouchers or manage various hospital, dentist and prescription appointments. In turn, this was identified as crucial in terms of providing hope when navigating institutional barriers and discrimination. When discussing the PHOENix visits, Lee stated that:

> People treat with you a wee bit more respect because they know there's somebody on your side. But when you've not got anybody on your side, they treat you the way they want to treat you. So, it gives you hope, do you know what I mean? They want somebody to live rather than die. (Lee)

Whilst the practical features of the PHOENIx intervention emerged as a substantial aspect of support for sustained hope and recovery, it is important to note that there is no one-size fits all approach and participants discussed a variety of third sector services that were highly valued. For instance, Simon Community provision enabled participants to access a variety of initiatives that created a support network and provided a safe environment where people did not feel judged. Chris stated that his complex needs worker enabled him to secure the housing support he needed:

> She linked me in with the right people, with the right help I needed at the right time [...] I've got two people coming out from Housing First to see me every week, they know that I'm going for intensive support tenancy [...] With the right support, anything is possible. (Chris)

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## Accommodation: Safe from harm

Finally, an overarching aspect of support that all participants expressed as essential in regards to drug use, overdose risk and homelessness involved access to safe accommodation. This was perceived as essential due to the unhappiness within emergency accommodation in contrast to the importance of warmth, food and a clean environment. For Thomas, he described the impact of being homelessness in Glasgow for the last three years, and stressed his current goal was securing safe accommodation and financial stability:

> Peace of mind, man, see just to be able to put my head down on the pillow and know that I've no harmed anybody or hurt anybody, that would be great. And knowing that nobody is going to try and come through my door to harm me [...] I would really like support with getting housing. I want my benefits sorted out as well. (Thomas)

Other participants stated that access to clean accommodation was a motivating factor that provided some hope for the future, with many associating a permanent house with security and safety, the most valued aspect of support. For Clare, who had been living in emergency accommodation followed by temporary accommodation, with damp issues, her main priority entailed securing permanent housing that would enable her to create a home:

> I suppose if I go into my own property; that would obviously motivate me more, I don't know if I would still need as much Valium. I think if I get my own house everything else will just fall into place. It's a massive thing to me. I just can't wait to have my own house and decorate it the way I want it. (Clare)

For others, perceptions of safety were related to escaping environments identified as specific risk factors for drug use and overdose such as 'enemies' and 'drug activity'. Many participants expressed a desire for a 'fresh start' and what this would envisage for them:

> A fresh start for me is an absence of drugs and a nice clean environment. As in house wise you know what I mean, a clean house, a safe place to stay and be warm [...] Where people aren't caught up in drug addiction. (Lee)

# Discussion

This study provides insight from those highly marginalised at the intersection of homelessness and non-fatal drug overdose. Our findings

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identify risk and protective factors for overdose from the perspective of those with living experience of both issues. Prominent messages emerged in relation to significant levels of re-traumatisation that participants identified as risk factors for current drug use and overdose. Consistent with research conducted by Schofield *et al.* (2022), this was associated with the impact of Covid-19, having exacerbated the multifaceted challenges people faced in regards to chronic physical and mental health conditions. However, in our study, unsafe experiences in unsupported emergency accommodation were at the forefront of risk factors, with concerns raised about the prevalence and accessibility of illicit street Valium, inadequate living conditions and the impact of consistently witnessing death. Whilst the *Everyone In* initiative saw rough sleepers placed into emergency accommodation during the height Covid-19, this policy may also have re-traumatised many in a toxic environment due to the prevalence of illicit drugs and unsuitable living conditions. Not only did participants report increased levels of anxiety and isolation, but they also emphasised difficulties securing statutory health and social care provision and highlighted specific multi-agency stressors that impacted upon their drug use and overdose risk. For the vast majority of participants, engagement with statutory services for substance use and mental health was described as challenging, inconsistent and stigmatising. This in turn left many unable to access necessary support, leading to a sense of discrimination, lack of autonomy and powerlessness. Contrastingly, all participants emphasised the necessity of third sector providers in particular, as vital in terms of both creating and sustaining 'hope', with the importance of advocacy and safe accommodation playing an integral part in cultivating recovery capital (Hennessy, 2017).

We suggest that there are several implications for integrated health and social care practice and policy that can support those experiencing both homelessness and drug use and reduce the risk of overdose. First, there is a pressing requirement to rethink aspects of current health and social care provision, informed by those with living experience. Many participants highlighted significant instances of abuse and institutionalised neglect, yet despite notions of trauma-informed approaches embedded within practice, it is important to question how and if this is being achieved currently within multi-agency settings in Scotland. Notably, the Scottish Government (2021) have published MAT standards, including standard 10: Trauma Informed Care and because this is in its infancy, we are yet to find out if the standard is achievable within the context of people experiencing homelessness who have had at least one recent non-fatal overdose. Second, the findings underline that many participants experienced feeling excluded from decision making and that drug treatments and decisions were imposed on them. This extends to Methadone Maintenance Treatment (MMT) in particular; participants often felt they were not listened to, denied access to detox/rehabilitation and

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experienced barriers when attempting to access counselling, particularly for bereavement. Nevertheless, for this particular group of people, the importance of health and third sector partnership working (e.g. NHS Pharmacist and third sector support worker) was highly valued, providing advocacy and a mechanism for sustained recovery alongside the hope for a better future. We also noted that whilst the study was being conducted none of the participants were being considered for Housing First intensive support despite the perceived benefits to individuals from the initiative (Johnsen *et al.*, 2021).

## Limitations

Our analyses were limited to those receiving the PHOENIx intervention and therefore our data and findings specifically relate to how this particular group of people experience health and social care services. Thus, purposeful sampling was utilised in order to identify individuals willing to communicate their living experience in order to capture an in-depth understanding within this niche context, rather than achieve a generalisation of results. We were aware of potential confirmation bias from Simon Community staff involved in the study and addressed this by ensuring that no single stakeholder's voice was relied upon and that it was a consensus approach by the research team as a whole. A strength of this study is that 35 per cent of participants identified as women, with gendered experiences such as domestic abuse and violence against women reported. Most notable were discussions highlighting negative interactions with the child protection system, leaving women expressing stigmatisation and powerlessness. Given that drug-related deaths amongst women in Scotland have increased, connected to changes within the social security system and health and social care provision (Tweed *et al.*, 2022), further interrogation into the impact of homelessness and drug overdose from a gendered perspective is essential for future research. Additionally, it is important to acknowledge this was not an ethnically diverse sample. Studies have suggested that whilst problematic drug use appears statistically uncommon amongst racially minoritised groups in Scotland, under-representation is inherent due to a lack of national data related to ethnicity alongside a reluctance to engage with addiction services (Coalition for Racial Equality and Rights, 2012). Further research is required to explore the perspectives of those who do not identify as White Scottish at the intersection of homelessness and drug use.

## Conclusion

This study demonstrates the detrimental impact of the Covid-19 pandemic within the context of increasing homelessness and drug-related

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deaths in Scotland. Participants described unsafe living conditions within unsupported emergency accommodation alongside an inability to access statutory services that contributed towards their drug use and risk of overdose. We propose that urgent action is required to assess the use of emergency unsupported accommodation for people at highest risk of drug-related death, such as those included in this study. Further regulatory investigation is needed to ascertain why this form of accommodation continues to be consistently provided despite Scotland's National Framework scaling up Housing First across all local authorities (Homeless Network Scotland, 2022). Multi-agency stressors are identified as sources of powerlessness, as the lack of autonomy within drug treatment plans and experiences of dehumanisation and abuse potentially escalate drug use. We found that understanding and responding to this specific context are crucial for participants, who placed particular value upon the role of third sector advocacy-based services. Specifically, having a tenacious caseworker was regarded as a priority to not only provide appropriate health and psychosocial support, but also ensure autonomy and choice are embedded in practice.

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